

**RECALL AUDIT**

State 53505 (2-08)  
Indiana State Department of Health  
Food Protection

<b>1. Recall Information</b>	a. Recall number:	
b. Recalling establishment:		
c. Recall codes ( <i>or see attached list</i> ):		
d. Product description:		
<b>2. Audit Accounts</b>	a. Establishment telephone:	
b. Establishment name:		
c. Establishment address ( <i>number &amp; street, city, state, zip code</i> ):		
<b>3. Firm in Possession of Product</b>	a. Person Interviewed:	
b. Title:	c. Date ( <i>month, day, year</i> ):	
d. Type of firm: <input type="checkbox"/> Warehouse <input type="checkbox"/> Manufacturer <input type="checkbox"/> Grocery Store <input type="checkbox"/> Restaurant <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Consumer <input type="checkbox"/> Other		
<b>4. Notification Data</b>	a. Did the firm receive the notice: <input type="checkbox"/> YES <input type="checkbox"/> NO	b. Date notified ( <i>month, day, year</i> ):
c. Received recall notification from: <input type="checkbox"/> Recalling firm <input type="checkbox"/> Direct account <input type="checkbox"/> Sub-account <input type="checkbox"/> Other		d. Type of notification: <input type="checkbox"/> Telephone <input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Other
<b>5. Action/Status Data</b>	a. Did the firm follow the recall instructions? <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. Amount of recalled product on hand at the time of notification?		
c. Current status of recalled items: <input type="checkbox"/> Returned <input type="checkbox"/> Corrected <input type="checkbox"/> Destroyed <input type="checkbox"/> None on Hand <input type="checkbox"/> Was still for sale/use* <input type="checkbox"/> Held for return/correction* *=Ensure proper quarantine/action		
d. Date and method of disposition ( <i>month, day, year</i> ):		
<b>6. Amount of Recalled Product on Hand:</b>		
<b>7. Injuries/Complaints</b>	a. Is the firm aware of any injuries, illness or complaints? <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Complaint <input type="checkbox"/> None	
<b>8. Additional Comments:</b>		
<b>9. Auditing County</b>	a. Name of county:	
b. Food specialist signature:	c. Audit date ( <i>month, day, year</i> ):	